

12471  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 CERTIFICATE OF DEATH

12450

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. LENGTH OF STAY IN 1b <b>40 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital of Cecil County</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Nan</b> Middle <b>S.</b> Last <b>Bates</b>				4. DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan 10, 1885</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>			
11. BIRTHPLACE (State or foreign country) <b>Petersburg, Va.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Melville Sterne</b>				14. MOTHER'S MAIDEN NAME <b>Ida Eanes</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Husband - J.H. Bates</b>				Address <b>Elkton, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis - Chronic Myocarditis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Nov 16, 1960</b> to <b>Nov. 18, 1960</b> , that I last saw the deceased alive on <b>Nov. 18, 1960</b> and that death occurred at <b>10:22 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>North East, Maryland</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Dr. H. A. Cantwell</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Dr. H. A. Cantwell</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>							
22b. DATE THEREOF <b>11/21/60</b>							
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>							
22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>PIPPIN FUNERAL HOME</b> ADDRESS <b>Elkton, Md.</b>							
24a. REC'D BY REGISTRAR DATE <b>NOV 22 '60</b>							
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanes</b>							

STATE OF OHIO  
DEPARTMENT OF HEALTH

12121

10

DATE

TIME

PLACE OF BIRTH

AGE

SEX

EDUCATION

OCCUPATION

CAUSE

DIAGNOSIS

DATE OF DEATH

SIGNATURE

DATE

PLACE

STATE OF OHIO

DEPARTMENT OF HEALTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12472

## CERTIFICATE OF DEATH

Reg. Dist. No.

12451

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Walnut Lane		d. STREET ADDRESS Walnut Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Lawrence Charles Bathon		4. DATE OF DEATH Month Day Year November 26, 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1923
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager		10b. KIND OF BUSINESS OR INDUSTRY Elk Paper	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME G. Howard Bathon		14. MOTHER'S MAIDEN NAME Nancy M. Syron	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 219-16-4987	
17. INFORMANT Daniel H. Bathon, Elkton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 45 minutes			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 26, 1960, to Nov. 26, 1960, that I last saw the deceased alive on Nov. 26, 1960, and that death occurred at 3:40 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE S. RALPH ANDREWS, JR., M.D. 233 E. Main Street 11/26/60 PHYSICIAN'S NAME (Type) Elkton Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/29/60	22c. NAME OF CEMETERY OR CREMATORY Immaculate Conception Cemetery, Elkton, Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks		24a. REC'D BY REGISTRAR DATE DEC 6 '60	
ADDRESS Elkton, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Hanks	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12452

Reg. Dist. No.

12488

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Cecil</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural North East</u>			c. LENGTH OF STAY IN 1b <u>12 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural North East</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>BERNARD</u> Middle <u>A</u> Last <u>BIBEY</u>				<b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>30</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 20, 1909</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Thiokol Chemical</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Frederick C. Bibey</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Right</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>232-10-1430</u>		17. INFORMANT Address <u>Mrs Luvenia Bibey North East R.D. Maryland</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420-1</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R.C. Dodson</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>12-1-1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-4-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stringtown</u>		22d. LOCATION (City, town, or county) (State) <u>Belington, Harbour Co., W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>				ADDRESS <u>North East, Maryland</u>		24a. REC'D BY REGISTRAR <u>DEC 2 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Clifford S. Grant</u>				24c. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records prior to burial, cremation, or removal.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. MARITAL STATUS	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF VENDOR		20. SIGNATURE OF CEMETERY		21. SIGNATURE OF INTERMENT	
22. SIGNATURE OF BURIAL		23. SIGNATURE OF CREMATION		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER	
94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12489

CERTIFICATE OF DEATH

12453

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Princess Anne</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bainbridge</u>				c. LENGTH OF STAY IN 1b <u>7 hrs 52 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Station Hospital, USNTC</u>				d. STREET ADDRESS <u>7948 Shore Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>Deborah</u> Middle <u>(n)</u> Last <u>Butcher</u>				4. DATE OF DEATH Month <u>November</u> Day <u>16</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 16, 1960</u>	
9. AGE (In years lost birthday) yrs. <u>7</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Alba Butcher</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Maybelle MacNeil</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>PREMATURITY</u> DUE TO (c) <u>PREMATURE LABOR, RUPTURED MARGINAL SINUS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs 52 min</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>November 16, 1960</u> , to <u>November 16, 1960</u> , that I last saw the deceased alive on <u>November 16, 1960</u> , and that death occurred at <u>3:31 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Paul C Horn</u> M.D. <u>Station Hospital, USNTC, Bainbridge 11-17-60</u> <u>Maryland</u> PHYSICIAN'S NAME (Type) <u>PAUL C. HORN, LT USNR Station Hospital, USNTC, Bainbridge, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-18-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Coloma Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson &amp; Son</u>				ADDRESS <u>Perryville, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE NOV 18 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

2051182XUO

CERTIFICATE OF DEATH

1918

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1873		BALTIMORE		MD		USA	
MARRIED		DATE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT	
YES		1905		1918		BALTIMORE		MD		USA		1918		BALTIMORE	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		SPECIAL INSTRUCTIONS		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
PNEUMONIA		NATURAL		LABORER		HIGH SCHOOL		METHODIST							
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT		COUNTRY OF INTERMENT	
1918		BALTIMORE		MD		USA		1918		BALTIMORE		MD		USA	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF		SIGNATURE OF CORONER	

1



12473

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b>		b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>20 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hosp.</b>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EDWARD</b>		First <b>F.</b>		Middle <b>CONNOR</b>	
Last <b>CONNOR</b>		4. DATE OF DEATH <b>November 17,</b>		19 <b>60</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 12, 1892</b>		9. AGE (In years last birthday) <b>67</b> yrs.	
IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Textile</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Delaware</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>James J. Connor</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Mc Ginnis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>		Address <b>Ethel K. Connor North East, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>Cardio-vascular failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>C.V.A., (Cerebral hemorrhage)</b> DUE TO (c) <b>Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b> <b>9 days</b> <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>H.C.V.D., G.A.S., A.S.C.V.D.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>North East, Md.</b>		(County) <b>North East</b>		(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>10-27-60</b> to <b>11-17-60</b> , that I last saw the deceased alive on <b>11-16-60</b> , and that death occurred at <b>2:40 am</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cecil Ave., North East, Md.</b> DATE SIGNED <b>Nov 22 1960</b>		ACTUAL SIGNATURE <b>Luiss M. Guza</b>		PHYSICIAN'S NAME (Type) <b>Luiss M. Guza</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/21/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Wilmington, Del.</b>		(State) <b>Del.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>PIP IN FUNERAL HOME</b>		ADDRESS <b>Elkton, Md.</b>		24a. REG'D. BY REGISTRAR <b>NOV 22 1960</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Thomas</b>					

**12.5 TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

VS A1S (4)  
ISM 9/5B

13401

CERTIFICATE OF DEATH

13401

BO

13401

13401

10 min

Cardio-vascular system

9 days

(General I heart failure)

at age

prolongation

x

13401, 13402, 13403, 13404

00 - 11 - 17 - 00

10 - 17 -

0

11 - 15 -

Local area

0.15, 0.15, 0.15

13401, 13402

12474

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			
c. LENGTH OF STAY IN 1b 14 yrs.				d. STREET ADDRESS Elkton, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Gertrude E. Cooper				4. DATE OF DEATH Month Day Year Nov. 9 19 60			
5. SEX Female		6. COLOR OR RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 2, 1886	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Benton				14. MOTHER'S MAIDEN NAME Sarah Young			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 215-32-0977			
17. INFORMANT Flossie Craven-107 Booth St.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Bronchopneumonia left lower lobe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Pyelonephritis left DUE TO (c) Arteriolisclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 2 Days 3 Years 3 Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7/4/1960, to 11/9/1960, that I last saw the deceased alive on 11/9/1960, and that death occurred at 7 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE James L. Johnson M.D. 245 East High Street 11/11/60 PHYSICIAN'S NAME (Type) James L. Johnson M. D. Elkton, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/13/60		22c. NAME OF CEMETERY OR CREMATORY Providence Cem.		22d. LOCATION (City, town, or county) (State) Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John A. Bell 909 Poplar St.				24a. REC'D BY REGISTRAR DATE NOV 16 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Farris	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 100-100

<p>1. NAME OF DECEASED                  [Illegible Name]</p>		<p>2. SEX                  [Illegible]</p>		<p>3. AGE                  [Illegible]</p>	
<p>4. DATE OF DEATH                  [Illegible]</p>		<p>5. TIME OF DEATH                  [Illegible]</p>		<p>6. PLACE OF DEATH                  [Illegible]</p>	
<p>7. CAUSE OF DEATH                  [Illegible]</p>		<p>8. MANNER OF DEATH                  [Illegible]</p>		<p>9. PLACE OF BIRTH                  [Illegible]</p>	
<p>10. OCCUPATION                  [Illegible]</p>		<p>11. EDUCATION                  [Illegible]</p>		<p>12. RELIGION                  [Illegible]</p>	
<p>13. MARITAL STATUS                  [Illegible]</p>		<p>14. DATE OF MARRIAGE                  [Illegible]</p>		<p>15. DATE OF DIVORCE                  [Illegible]</p>	
<p>16. NAME OF PHYSICIAN                  [Illegible]</p>		<p>17. NAME OF HOSPITAL                  [Illegible]</p>		<p>18. NAME OF NURSE                  [Illegible]</p>	
<p>19. NAME OF CORONER                  [Illegible]</p>		<p>20. NAME OF JURY                  [Illegible]</p>		<p>21. NAME OF JUDGE                  [Illegible]</p>	
<p>22. NAME OF WITNESS                  [Illegible]</p>		<p>23. NAME OF WITNESS                  [Illegible]</p>		<p>24. NAME OF WITNESS                  [Illegible]</p>	
<p>25. NAME OF WITNESS                  [Illegible]</p>		<p>26. NAME OF WITNESS                  [Illegible]</p>		<p>27. NAME OF WITNESS                  [Illegible]</p>	
<p>28. NAME OF WITNESS                  [Illegible]</p>		<p>29. NAME OF WITNESS                  [Illegible]</p>		<p>30. NAME OF WITNESS                  [Illegible]</p>	
<p>31. NAME OF WITNESS                  [Illegible]</p>		<p>32. NAME OF WITNESS                  [Illegible]</p>		<p>33. NAME OF WITNESS                  [Illegible]</p>	
<p>34. NAME OF WITNESS                  [Illegible]</p>		<p>35. NAME OF WITNESS                  [Illegible]</p>		<p>36. NAME OF WITNESS                  [Illegible]</p>	
<p>37. NAME OF WITNESS                  [Illegible]</p>		<p>38. NAME OF WITNESS                  [Illegible]</p>		<p>39. NAME OF WITNESS                  [Illegible]</p>	
<p>40. NAME OF WITNESS                  [Illegible]</p>		<p>41. NAME OF WITNESS                  [Illegible]</p>		<p>42. NAME OF WITNESS                  [Illegible]</p>	
<p>43. NAME OF WITNESS                  [Illegible]</p>		<p>44. NAME OF WITNESS                  [Illegible]</p>		<p>45. NAME OF WITNESS                  [Illegible]</p>	
<p>46. NAME OF WITNESS                  [Illegible]</p>		<p>47. NAME OF WITNESS                  [Illegible]</p>		<p>48. NAME OF WITNESS                  [Illegible]</p>	
<p>49. NAME OF WITNESS                  [Illegible]</p>		<p>50. NAME OF WITNESS                  [Illegible]</p>		<p>51. NAME OF WITNESS                  [Illegible]</p>	
<p>52. NAME OF WITNESS                  [Illegible]</p>		<p>53. NAME OF WITNESS                  [Illegible]</p>		<p>54. NAME OF WITNESS                  [Illegible]</p>	
<p>55. NAME OF WITNESS                  [Illegible]</p>		<p>56. NAME OF WITNESS                  [Illegible]</p>		<p>57. NAME OF WITNESS                  [Illegible]</p>	
<p>58. NAME OF WITNESS                  [Illegible]</p>		<p>59. NAME OF WITNESS                  [Illegible]</p>		<p>60. NAME OF WITNESS                  [Illegible]</p>	
<p>61. NAME OF WITNESS                  [Illegible]</p>		<p>62. NAME OF WITNESS                  [Illegible]</p>		<p>63. NAME OF WITNESS                  [Illegible]</p>	
<p>64. NAME OF WITNESS                  [Illegible]</p>		<p>65. NAME OF WITNESS                  [Illegible]</p>		<p>66. NAME OF WITNESS                  [Illegible]</p>	
<p>67. NAME OF WITNESS                  [Illegible]</p>		<p>68. NAME OF WITNESS                  [Illegible]</p>		<p>69. NAME OF WITNESS                  [Illegible]</p>	
<p>70. NAME OF WITNESS                  [Illegible]</p>		<p>71. NAME OF WITNESS                  [Illegible]</p>		<p>72. NAME OF WITNESS                  [Illegible]</p>	
<p>73. NAME OF WITNESS                  [Illegible]</p>		<p>74. NAME OF WITNESS                  [Illegible]</p>		<p>75. NAME OF WITNESS                  [Illegible]</p>	
<p>76. NAME OF WITNESS                  [Illegible]</p>		<p>77. NAME OF WITNESS                  [Illegible]</p>		<p>78. NAME OF WITNESS                  [Illegible]</p>	
<p>79. NAME OF WITNESS                  [Illegible]</p>		<p>80. NAME OF WITNESS                  [Illegible]</p>		<p>81. NAME OF WITNESS                  [Illegible]</p>	
<p>82. NAME OF WITNESS                  [Illegible]</p>		<p>83. NAME OF WITNESS                  [Illegible]</p>		<p>84. NAME OF WITNESS                  [Illegible]</p>	
<p>85. NAME OF WITNESS                  [Illegible]</p>		<p>86. NAME OF WITNESS                  [Illegible]</p>		<p>87. NAME OF WITNESS                  [Illegible]</p>	
<p>88. NAME OF WITNESS                  [Illegible]</p>		<p>89. NAME OF WITNESS                  [Illegible]</p>		<p>90. NAME OF WITNESS                  [Illegible]</p>	
<p>91. NAME OF WITNESS                  [Illegible]</p>		<p>92. NAME OF WITNESS                  [Illegible]</p>		<p>93. NAME OF WITNESS                  [Illegible]</p>	
<p>94. NAME OF WITNESS                  [Illegible]</p>		<p>95. NAME OF WITNESS                  [Illegible]</p>		<p>96. NAME OF WITNESS                  [Illegible]</p>	
<p>97. NAME OF WITNESS                  [Illegible]</p>		<p>98. NAME OF WITNESS                  [Illegible]</p>		<p>99. NAME OF WITNESS                  [Illegible]</p>	
<p>100. NAME OF WITNESS                  [Illegible]</p>		<p>101. NAME OF WITNESS                  [Illegible]</p>		<p>102. NAME OF WITNESS                  [Illegible]</p>	

12475

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 35 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 102 South Street				d. STREET ADDRESS 1 102 South Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLARENCE First E. Middle DENNEY Last				4. DATE OF DEATH November 24, 1960 Month Day Year			
5. SEX White		6. COLOR OR RACE male		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 24, 1901	
9. AGE (In years last birthday) 59 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Town of Elkton		10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) Delaware	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME J. Franklin Denney		14. MOTHER'S MAIDEN NAME Lillian Powell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Edna M. Denney Elkton, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic coronary artery disease DUE TO (c) several yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 5 minutes	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1, 1957, to Nov. 24, 1960, that I last saw the deceased alive on Nov. 23, 1960, and that death occurred at 12:30a M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE S. Ralph Andrews, Jr., M.D. M.D. 235 E. Main Street 11/24/60 PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, JR., M.D. Elkton, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 27, 1960		22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME Donald M. Dee Elkton, Md.				24a. REC'D BY REGISTRAR DATE NOV 28 '60		24b. REGISTRAR'S SIGNATURE Arthur J. Hines	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12457

12490

Item 1 Film C275 11-22-60 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Delaware b. COUNTY New Castle			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. LENGTH OF STAY IN TB P.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilmington 46X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Found dead (Behind McMullen Bros. Garage)				d. STREET ADDRESS 813 Madison St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Walter Middle C. Last Fisher				4. DATE OF DEATH Month Nov. Day 12 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 17, 1897		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY House		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Walter Fisher				14. MOTHER'S MAIDEN NAME Clara Adams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes. 1st & 2nd W.W.		16. SOCIAL SECURITY NO. ?		17. INFORMANT Address Eva Roman, 813 Madison St., Wilmington Delaware.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 42001 DUE TO (b) Arterio Sclerotic Cardiac Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R. C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-15-1960		22c. NAME OF CEMETERY OR CREMATORY West Nottingham		22d. LOCATION (City, town, or county) (State) E Colora, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son				ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR DATE NOV 16 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thoma			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15430

NAME OF DECEASED JAMES J. BARNHART		AGE 65		SEX Male		RACE White		DATE OF DEATH 10-15-1917		PLACE OF DEATH Home	
RESIDENCE 1015 1st St. N. Minneapolis, Minn.		OCCUPATION Carpenter		EDUCATION High School		MARRIAGE Married		RELIGION Roman Catholic		POLITICAL PARTY None	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		DISEASE OR INJURY Coronary Artery Disease		SYMPTOMS Chest pain, shortness of breath		TREATMENT None		HISTORY None	
SIGNATURE OF EXAMINER J. J. Barnhart		DATE 10-15-1917		PLACE Minneapolis, Minn.		TIME 10:00 AM		WITNESSES None		FAMILY HISTORY None	
MEDICAL HISTORY None		SURGICAL HISTORY None		LABORATORY TESTS None		X-RAY None		AUTOPSY None		OTHER None	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 & 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

12491

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12458

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN lb <b>3yrs. 6mo. 3days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>1691 Darley Avenue</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>FRANCIS N. FOLEY</b>		4. DATE OF DEATH Month Day Year <b>November 25 19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-18-19</b>
9. AGE (In years lost birthday) <b>41</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Patrick J. Foley</b>		14. MOTHER'S MAIDEN NAME <b>Kat Carrie Schrott</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW II 218-07-6389</b>	
17. INFORMANT <b>Catherine Foley, sister, 5635 Ready Ave.</b>		Address <b>Baltimore, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary thrombosis</b> DUE TO (c) <b>Arteriosclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>8 days</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>the</del> (hospital) attended the deceased from <b>May 22 1957</b> to <b>November 25 1960</b> that the deceased was <del>born</del> <b>born</b> on <b>August 18 1919</b> and that death occurred <b>at 6:55 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>A. L. Mooney</b>		22b. DATE SIGNED <b>11-29-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. L. MOONEY Asst. Clinical Pathologist, VAH, Perry Point, Md.</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE THEREOF <b>11/30/1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bennington &amp; Son</b>		25a. REC'D BY REGISTRAR <b>DEC 5 '60</b>	
ADDRESS <b>Havre de Grace, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Christina S. Hanna</b>	

12481

CERTIFICATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. For to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

12492

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12459

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East R.D.</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence Alonzo Fritz</u>				4. DATE OF DEATH Month Day Year <u>11 19 60</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>10-19-1896</u>		9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Disabled Vet.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alonzo W. Fritz</u>				14. MOTHER'S MAIDEN NAME <u>Marinda Lister</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>W.W.I</u>		16. SOCIAL SECURITY NO. <u>222-103-7961</u>		17. INFORMANT Address <u>Edward J. Fritz Perryville Rd Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Partial decapitation of head</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>976X</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Placed shot gun in mouth and set it off</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>11</u> <u>pm.</u> <u>1119</u> <u>19</u> <u>60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>North East Cecil Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R.C. Dodson</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-23-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Middletown Presbyterian</u>		22d. LOCATION (City, town, or county) (State) <u>Chester Co. Penna</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>				ADDRESS <u>North East, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 22 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death	
6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Medical Examiner	
11. Signature of Coroner		12. Signature of Physician		13. Signature of Medical Examiner		14. Signature of Medical Examiner		15. Signature of Medical Examiner	
16. Signature of Medical Examiner		17. Signature of Medical Examiner		18. Signature of Medical Examiner		19. Signature of Medical Examiner		20. Signature of Medical Examiner	
21. Signature of Medical Examiner		22. Signature of Medical Examiner		23. Signature of Medical Examiner		24. Signature of Medical Examiner		25. Signature of Medical Examiner	
26. Signature of Medical Examiner		27. Signature of Medical Examiner		28. Signature of Medical Examiner		29. Signature of Medical Examiner		30. Signature of Medical Examiner	
31. Signature of Medical Examiner		32. Signature of Medical Examiner		33. Signature of Medical Examiner		34. Signature of Medical Examiner		35. Signature of Medical Examiner	
36. Signature of Medical Examiner		37. Signature of Medical Examiner		38. Signature of Medical Examiner		39. Signature of Medical Examiner		40. Signature of Medical Examiner	
41. Signature of Medical Examiner		42. Signature of Medical Examiner		43. Signature of Medical Examiner		44. Signature of Medical Examiner		45. Signature of Medical Examiner	
46. Signature of Medical Examiner		47. Signature of Medical Examiner		48. Signature of Medical Examiner		49. Signature of Medical Examiner		50. Signature of Medical Examiner	
51. Signature of Medical Examiner		52. Signature of Medical Examiner		53. Signature of Medical Examiner		54. Signature of Medical Examiner		55. Signature of Medical Examiner	
56. Signature of Medical Examiner		57. Signature of Medical Examiner		58. Signature of Medical Examiner		59. Signature of Medical Examiner		60. Signature of Medical Examiner	
61. Signature of Medical Examiner		62. Signature of Medical Examiner		63. Signature of Medical Examiner		64. Signature of Medical Examiner		65. Signature of Medical Examiner	
66. Signature of Medical Examiner		67. Signature of Medical Examiner		68. Signature of Medical Examiner		69. Signature of Medical Examiner		70. Signature of Medical Examiner	
71. Signature of Medical Examiner		72. Signature of Medical Examiner		73. Signature of Medical Examiner		74. Signature of Medical Examiner		75. Signature of Medical Examiner	
76. Signature of Medical Examiner		77. Signature of Medical Examiner		78. Signature of Medical Examiner		79. Signature of Medical Examiner		80. Signature of Medical Examiner	
81. Signature of Medical Examiner		82. Signature of Medical Examiner		83. Signature of Medical Examiner		84. Signature of Medical Examiner		85. Signature of Medical Examiner	
86. Signature of Medical Examiner		87. Signature of Medical Examiner		88. Signature of Medical Examiner		89. Signature of Medical Examiner		90. Signature of Medical Examiner	
91. Signature of Medical Examiner		92. Signature of Medical Examiner		93. Signature of Medical Examiner		94. Signature of Medical Examiner		95. Signature of Medical Examiner	
96. Signature of Medical Examiner		97. Signature of Medical Examiner		98. Signature of Medical Examiner		99. Signature of Medical Examiner		100. Signature of Medical Examiner	

Partial decapitation of head

03-7961 Edward J. Fritz Perryville Rd Maryland



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

12493  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12460

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN 1b <b>35yr 4mo 22 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2621 Dulaney Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>A.</b> Last <b>GERWIG</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>18</b> Year <b>1960</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12- -96</b>	9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months <b>63</b>	IF UNDER 24 HRS. Days <b>18</b> Hours <b>18</b> Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Charles Gerwig</b>		14. MOTHER'S MAIDEN NAME <b>Mary (Unknown)</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW1</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>2615 Daisy Avenue, (brother)</b> <b>Jacob F. Gerwig, Baltimore, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction.</b> DUE TO (b) <b>Coronary Thrombosis</b> DUE TO (c) <b>Arteriosclerotic heart disease.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4-5 days</b> <b>4-5 days</b> <b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that <b>A. L. Mooney</b> attended the deceased from <b>June 26</b> 19 <b>60</b> to <b>Nov. 18</b> 19 <b>60</b> and that death occurred at <b>9:20PM</b> from the causes and on the date stated above.						
22a. SIGNATURE <b>A. L. Mooney</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>November 19, 1960</b>		
22c. PHYSICIAN'S NAME (Type) <b>A. L. MOONEY, M.D.</b>		22d. ADDRESS <b>VAH., Perry Point, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE THEREOF <b>11-23-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>PENNINGTON &amp; SON</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 23 '60</b>		25b. REGISTRAR'S SIGNATURE <b>John S. K...</b>

MEDICAL CERTIFICATION

1940

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1840

1. Name of deceased: James A. Smith

2. Sex: Male

3. Age: 45

4. Date of birth: Jan. 15, 1895

5. Place of birth: St. Louis, Mo.

6. Date of death: Jan. 20, 1940

7. Place of death: St. Louis, Mo.

8. Cause of death: Heart disease

9. Signature of physician: Dr. J. H. Jones

10. Signature of registrar: John D. Smith

11. Date of registration: Jan. 21, 1940

12. Place of registration: St. Louis, Mo.

12497

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL North East		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL North East			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last George N. Gray				4. DATE OF DEATH Month Day Year 11 19 1960			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1878	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Paper hanger and painter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Gray				14. MOTHER'S MAIDEN NAME Jenny Field			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs Herman Marr North East R.D. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 12 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. — 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from May 1947, to 19 Nov 1960, that I last saw the deceased alive on 1 Nov 1960, and that death occurred at 5:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Klaus H. Huchner M.D.				ADDRESS (Street, city or town, state) North East Rd		DATE SIGNED 19 Nov '60	
PHYSICIAN'S NAME (Type) Klaus H. Huchner							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-22-1960	22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) (State) North East, Cecil Co., Md			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant North East, Maryland				24a. REC'D BY REGISTRAR DATE NOV 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. For a burial-cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12495 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12462

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>		c. LENGTH OF STAY IN 1b <u>29 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		3V91-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>2001 E. Fairmount Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LAWRENCE HEIMEL</u>				4. DATE OF DEATH Month Day Year <u>Nov. 26 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 30, 1892</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Huckster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Heimel</u>			14. MOTHER'S MAIDEN NAME <u>Mary Yager</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>2001 E. Fairmount Ave., Bernard Heimel, Baltimore, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Large Meningioma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Died while removing tumor</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>William</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>B. C. DODSON, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <u>11-26-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Nov. 30-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Fredrick Rd. Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lippel Bros. 1800 E. Lombard St.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	



1192

1

2



may be returned by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

12487

12463

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit</b>				c. LENGTH OF STAY IN 1b <b>73 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>S. Main St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Eshleman</b> Last <b>Kimble</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>19</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 14, 1887</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		10. UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13. FATHER'S NAME <b>James Eshleman</b>				14. MOTHER'S MAIDEN NAME <b>Ida Webb</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Chester T. Kimble, Sr. Port Deposit, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Cerebro Vascular Accident</b> DUE TO <b>Hypertensive Cerebro Vascular Disease</b> (b) <b>Generalized Arterio-sclerosis</b> DUE TO <b>10 yrs</b> (c) <b>10 yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b> <b>10 yrs</b> <b>10 yrs</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 10</b> <b>1954</b> to <b>Nov 19</b> <b>1960</b> , that (I) (we) last saw the deceased alive on <b>11-19</b> <b>1960</b> , and that death occurred at <b>11:30</b> <b>A.M.</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>G.H. Richards Jr.</b>				22b. DATE SIGNED <b>11/20/60</b>		22c. PHYSICIAN'S NAME (Type) <b>G.H. Richards Jr. M.D.</b>	
22d. ADDRESS <b>Port Deposit, Md.</b>							
23a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-22-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hopewell</b>		23d. LOCATION (City, town, or county) (State) <b>Port Deposit, Md. Rural</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John Patterson &amp; Sons</b>				ADDRESS <b>Perryville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 23 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

## 1548

• 324 •

CERTIFICATE OF DEATH

12464

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Philip</u> Middle <u>N.</u> Last <u>King</u>		4. DATE OF DEATH Month <u>November</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25, 1897</u>
9. AGE (In years last birthday) <u>62 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hardware Merchant (ret.)</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Samuel King</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret McCaffety</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W.W.I</u>	
16. SOCIAL SECURITY NO. <u>213-09-9081</u>		INFORMANT <u>Miss Patricia M. King, 108 Bow St., Elkton, Md.</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis - E. I. Hemorrhage</u> 541.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Perforated Duodenal Ulcer</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6d</u> <u>6d</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Heart Failure - Pulmonary Emphysema</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 17)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/13</u> 19 <u>60</u> to <u>11/18</u> 19 <u>60</u> , that I last saw the deceased alive on <u>11/18</u> 19 <u>60</u> and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph R. Lanzini</u> M.D.		ADDRESS (Street, city or town, state) <u>205 W Main St Elkton Md</u>	
PHYSICIAN'S NAME (Type) <u>Joseph C. Lanzini</u>		DATE SIGNED <u>11/19/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-21-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Immaculate Conception Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Elkton Cecil Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Lanzini</u>		24a. REC'D BY REGISTRAR <u>North East, Maryland.</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1510

CERTIFICATE OF DEATH

1510

1510



12477

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 60 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY <del>XXXXXXXX</del> ANN LEIBIG		4. DATE OF DEATH November 23, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 4, 1879
9. AGE (In years lost birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Hammell		14. MOTHER'S MAIDEN NAME Rose O'Dougherty	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-32-0674	
17. INFORMANT Mrs. Rose M. Boyles		Address Nr. Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Acute Pulmonary Edema (b) Congestive Heart Failure (c) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1960 to Nov 22, 1960 that I last saw the deceased alive on Nov 22, 1960, and that death occurred at 12:55 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph G. Lanzi		ADDRESS (Street, city or town, state) 205 W Main St Elkton, Md.	
PHYSICIAN'S NAME (Type) Joseph G. Lanzi		DATE SIGNED 11/23/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 26, 1960	
22c. NAME OF CEMETERY OR CREMATORY Immaculate Conception Cemetery		22d. LOCATION (City, town, or county) (State) Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME Donald H. Lee		ADDRESS Elkton, Md.	
24a. REC'D BY REGISTRAR DATE NOV 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Knauss	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

1917

(M)

County of Albany State of New York  
I, John J. [illegible] Registrar  
do hereby certify that on the 15th day of November  
1917, at Albany, New York, John J. [illegible]  
aged 60 years, died of Heart Disease  
Cause of Death Myocardial Infarction  
Died at Home  
Buried at St. John's Church  
Burial place Albany  
Witness my hand and the seal of the Department of Health  
at Albany, New York, this 15th day of November, 1917.

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the document]*



## CERTIFICATE OF DEATH

12466

Reg. Dist. No.

12478

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b <u>75 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>131 Milburn</u>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>-</u> Last <u>Logan</u>				4. DATE OF DEATH Month <u>11-</u> Day <u>--11</u> Year <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>- - 1865</u>		9. AGE (In years last birthday) <u>95</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pulp Mill &amp; Old work</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jerry Logan</u>				14. MOTHER'S MAIDEN NAME <u>Rye -</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>222-05-2479</u>		17. INFORMANT <u>Magline Byrd 131 Milburn St., Elkton, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremic Coma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Parenchymatous Nephritis</u> DUE TO (c) <u>Myocarditis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u> <u>5 Years</u> <u>5 Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/16/</u> 19 <u>55</u> to <u>11/11/</u> 19 <u>60</u> , that I last saw the deceased alive on <u>11/11/</u> 19 <u>60</u> , and that death occurred at <u>1 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James L. Johnson</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>245 East High Street 11/12/60</u>			
PHYSICIAN'S NAME (Type) <u>James L. Johnson M. D.</u>				<u>Elkton, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-15-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Elkton Colored</u>		22d. LOCATION (City, town, or county) (State) <u>Elkton, Cecil Co., Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u> ADDRESS <u>North East Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 17 '60</u>		24b. REGISTRAR'S SIGNATURE <u>C. P. K.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

15478

Reg. No. 10

PLACE IN DEATH		MAY 1948	
DATE OF DEATH		MAY 1948	
TIME OF DEATH		MAY 1948	
PLACE OF DEATH		MAY 1948	
CAUSE OF DEATH		MAY 1948	
MANNER OF DEATH		MAY 1948	
AGE		MAY 1948	
SEX		MAY 1948	
RACE		MAY 1948	
EDUCATION		MAY 1948	
OCCUPATION		MAY 1948	
MARRIAGE		MAY 1948	
RELIGION		MAY 1948	
BIRTH		MAY 1948	
DEATH		MAY 1948	
SIGNATURE		MAY 1948	
DATE		MAY 1948	

15478

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

12496  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

Reg. Dist. No.

12467

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Elkton		c. LENGTH OF STAY IN 1b 88 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS R. D. 5	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ELWOOD LOTMAN		4. DATE OF DEATH November 15 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 3, 1872
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Cecil County		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Lotman		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT George E. Foster		Address Elkton, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Dehydration DUE TO (c) Chronic Parenchymatous		INTERVAL BETWEEN ONSET AND DEATH 6 Weeks 6 Weeks 4 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/2/1960 to 11/13/1960, that I last saw the deceased alive on 11/13/1960, and that death occurred at 7 P. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE James L. Johnson M.D.		245 East High Street 11/18/60	
PHYSICIAN'S NAME (Type) James L. Johnson M. D.		Elkton, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 18, 1960	
22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton Cecil County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks		ADDRESS Elkton, Maryland	
24a. REC'D BY REGISTRAR DATE NOV 23 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Howard	



may be returned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12497  
CERTIFICATE OF DEATH

12468

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cecilton</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cecilton</b>			
				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>S.</b> Middle <b>Wills</b> Last <b>Lusby</b>				4. DATE OF DEATH Month <b>November</b> Day <b>22</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 1, 1880</b>	
9. AGE (In years lost birthday) yrs. <b>80</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Z. Porter Lusby</b>				14. MOTHER'S MAIDEN NAME <b>Mary Willis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>				16. SOCIAL SECURITY NO. <b>None</b>			
INFORMANT <b>Son.</b>				Address <b>Mr. Eldridge Lusby, Cecilton, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary sclerosis</b> DUE TO (c) <b>Arteriosclerosis</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>one hour</b> <b>years</b> <b>years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of prostate with phlebothrombosis.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>Aug</b> , 19 <b>60</b> , to <b>22 Nov</b> , 19 <b>60</b> that I last saw the deceased alive on <b>22 Nov</b> , 19 <b>60</b> , and that death occurred at <b>5:00 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>22 Nov 60</b>							
ACTUAL SIGNATURE <b>Wallace Obenshain</b>				M.D. <b>22 Nov 60</b>			
PHYSICIAN'S NAME (Type) <b>Wallace Obenshain, MD,</b>				<b>Cecilton, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 25, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Stephens Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Earleville, Rural. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows</b>				ADDRESS <b>Phillington, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 28 60</b>	
						24b. REGISTRAR'S SIGNATURE <b>Charles E. King</b>	

BP

1248

CERTIFICATE OF DEATH

1248

1248

Death

Age

Color

Occupation

Residence

November

Friday

1910

1910

1910

1910

U.S.A.

Age

Residence

Residence

Family Name

Family Name

Sex

Color

Color

Occupation

Residence

Residence

Residence

Residence

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may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12498

12469

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Liberty Grove, Md.</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Liberty Grove</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Ernest</b> Middle <b>Bayard</b> Last <b>McCardell</b>				<b>4. DATE OF DEATH</b> Month <b>Nov.</b> Day <b>4</b> Year <b>1960</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>July 27, 1879</b>	
<b>9. AGE</b> (In years lost birthday) <b>81</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Carpender</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>George W. McCardell</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Anna McDowell</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>219-18-9992</b>		<b>17. INFORMANT</b> Address <b>Md.</b> <b>Mrs. Lidie M. McCardell, Liberty Grove,</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422-1</b> <b>Arterio Sclerosis -</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>13 yrs -</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Ch. Myocarditis -</b>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Sept 2nd 1955</b> <b>Nov 3 - 60</b> <b>19</b> , that (I) (we) last saw the deceased alive on <b>Nov 3 1960</b> , and that death occurred at <b>11</b> M, from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>Clarence I. Benson</b> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Clarence I. Benson</b> M.D.				<b>22d. ADDRESS</b> <b>Perryville, Md.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Nov. 7, 1960</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Harmony Chapel Cem.</b>		<b>23d. LOCATION (City, town, or county) (State)</b> <b>Liberty Grove, Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Lee A. Patterson &amp; Son</b>				<b>ADDRESS</b> <b>Perryville, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>Nov 9 '60</b>	
				<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. House</b>			

BP

12482

CERTIFICATE OF MARRIAGE

12482

1901

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

12479

12470

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lizzie Middle W. Last McCoy		4. DATE OF DEATH Month Nov. Day 27, Year 19 60	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1876
9. AGE (In years lost birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Clerk		10b. KIND OF BUSINESS OR INDUSTRY General	
11. BIRTHPLACE (State or foreign country) Chesapeake City, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Cummons		14. MOTHER'S MAIDEN NAME Sallie Borem	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-32-4156	
17. INFORMANT Mrs. Hazel M. Ragan, Conowingo, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis of Occlusory type</u> 170 X DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Cerebral Arteriosclerosis (Hypertension)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE-CONDITION GIVEN IN PART I (a) <u>severe malnutrition</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1939 to Nov. 27, 1960, that I last saw the deceased alive on Nov. 27, 1960, and that death occurred at 1:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry V. Davis		ADDRESS (Street, city or town, state) CHESAPEAKE CITY	
PHYSICIAN'S NAME (Type) HENRY V. DAVIS M.D.		DATE SIGNED 11/28/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-30-60	
22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Chesapeake City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

12-1-30

12-1-30

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

12499

12471

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elk Mills		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elk Mills	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) ELIZABETH First B. Middle Mc DANIEL Last		4. DATE OF DEATH November 30, 1960 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 22, 1891
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry W. Downham		14. MOTHER'S MAIDEN NAME Laura Lloyd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Delbert W. Mc Daniel		Address Elk Mills, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH 2-Hours 3-Years 8-Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 10, 1957, to 11/30/1960, that I last saw the deceased alive on 11/25/1960, and that death occurred at 11:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 245 East High Street 12/2/60			
ACTUAL SIGNATURE James L. Johnson M.D.		PHYSICIAN'S NAME (Type) James L. Johnson M.D. Elkton, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/3/60	
22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cherry Hill, Maryland	
23. BURIAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		ADDRESS Elkton, Md.	
24a. REC'D BY REGISTRAR DATE DEC 5 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

CERTIFICATE OF DEATH

1943

FILE NO.

DEATH NO.

DEATH NO.

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12486 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12472

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>			c. LENGTH OF STAY IN 1b <u>1 year</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print)      First      Middle      Last <u>Catherine</u> <u>E.</u> <u>McGuirk</u>				<b>4. DATE OF DEATH</b> Month      Day      Year <u>November</u> <u>3</u> <u>19 60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 25, 1876</u>		9. AGE (In years last birthday) <u>84 yrs.</u>	IF UNDER 1 YEAR      IF UNDER 24 HRS. Months      Days      Hours      Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isaac Galloway</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hargraves</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT      Address <u>Mrs. Curtis Fisher, Rising Sun, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> <u>420.1</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY      Month, Day, Year Hour      a. m.      p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)      (County)      (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R. C. Dodson</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11/3/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/6/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Principio Cemetery</u>		22d. LOCATION (City, town, or county)      (State) <u>Principio Furnace, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marion Lee Patterson</u>				ADDRESS <u>Perryville, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 9 1960</u>	
24b. REGISTRAR'S SIGNATURE				24c. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

12500  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12473

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 03X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 9633 Dixon Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MIDDLE Last JOSEPH I. MEADOWCROFT		4. DATE OF DEATH Month November Day 4 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-30-96
9. AGE (In years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor (retired)		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Meadowcroft (Deceased)		14. MOTHER'S MAIDEN NAME Mary Ellen Mac Elroy (Deceased)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW-I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Edna E. Meadowcroft, wife, 9633 Dixon Ave.		Address Baltimore, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident (Basilar artery Thrombosis) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema, senile		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>JOSEPH I. MEADOWCROFT</del> attended the deceased from <del>October 7, 1960</del> to <del>November 4, 1960</del> and that death occurred at <del>4:10 p.m.</del> from the causes and on the date stated above.			
22a. SIGNATURE		22b. DATE SIGNED 11-4-60	
22c. PHYSICIAN'S NAME (Type) L.G. CIAN, Chief Resident, Surgical Service, VAH, Perry Point, Md.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) 11-7-60		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION (City, town or county) Balto Md	
24. FUNERAL DIRECTOR'S SIGNATURE L. G. Luck 5305 Bayford		25a. REC'D BY REGISTRAR NOV 7 '60	
25b. REGISTRAR'S SIGNATURE			

09251

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12480 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12474

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE N. Y. b. COUNTY Queens	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) passing in boat Jamaica	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital D.O.A.		d. STREET ADDRESS 165-22 144 Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN H. MEYER		4. DATE OF DEATH Month Day Year 11 11 19 60	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-12-1914
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (State or foreign country) B'oklyn, N. Y.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Meyer	
14. MOTHER'S MAIDEN NAME Elizabeth Marback		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 051-16-7713		17. INFORMANT Mrs. Elizabeth Meyer, Jamaica, N. Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416 X Acute Coronary Arterio sclerotic DUE TO (b) Thrombotic Occlusion Rheumatic Heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Disease DUE TO (c) Disease		INTERVAL BETWEEN ONSET AND DEATH 5 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11-11-60	
EXAMINER'S NAME (Type) R. C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-16-60	22c. NAME OF CEMETERY OR CREMATORY Evergreens Cemetery	22d. LOCATION (City, town, or county) (State) Brooklyn, N. Y.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME		24a. REC'D BY REGISTRAR DATE NOV 15 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for a burial-cremation, or removal.







12481

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>N.C. 46X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. LENGTH OF STAY IN 1b <u>6 HAS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY ELIZABETH MUCH</u>		4. DATE OF DEATH Month <u>11</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-23-1919</u>
9. AGE (In years lost birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	11. IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>South Bend, Ind.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LADUILLAS KOVACH</u>		14. MOTHER'S MAIDEN NAME <u>MARY TURI</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>308-07-9854</u>	
17. INFORMANT <u>OTTO MUCH - SAME</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Coma</u> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cholemia</u> DUE TO (c) <u>Cirrhosis of liver</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>1 Month.</u> <u>Unknown.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>hypertensive vascular disease.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>59</u> , to <u>11-11</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>11-11</u> , 19 <u>60</u> , and that death occurred at <u>3 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Williford Eppes</u>		ADDRESS (Street, city or town, state) <u>327 E MAIN ST NEWARK DELAWARE</u>	
PHYSICIAN'S NAME (Type) <u>Williford Eppes MD</u>		DATE SIGNED <u>11/11/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-15-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Highland Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>S. Bend, INDIANA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Warwick</u>		ADDRESS <u>Newark Dela</u>	
24a. REC'D BY REGISTRAR <u>NOV 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1841

1. Name of deceased: John Doe

2. Age: 45

3. Sex: Male

4. Date of death: Jan 15 1841

5. Place of death: at home

6. Cause of death: Consumption

7. Signature of physician: Dr. J. Smith

8. Signature of witness: John Doe

9. Signature of registrar: John Doe

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your use for a burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12501

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12476

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE California b. COUNTY Los Angeles ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Verne 42X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PRR Railroad Tracks		d. STREET ADDRESS 2416 -2nd Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MANUEL Middle Last PEARCE		4. DATE OF DEATH Month 11 Day 14 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-11-35
9. AGE (In years last birthday) 25 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Shanghai, China		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Archie Pearce		14. MOTHER'S MAIDEN NAME Mercedes Garcia	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Lessie Pearce, 2416 2nd St., La Verne, Calif.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mutilated Body With Partial Decapitation Of Head. Amputated Right Leg DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 3:21 p.m. 11-14 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) PRR Tracks		20f. (City or town) (County) (State) Perryville Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. DODSON, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. DODSON, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 11-14-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/21/60	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE NOV 23 1960	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, or other person, should be filled with page 3 & 4, and be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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12502  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12477

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. STREET ADDRESS 106 West Mason Avenue	
3. NAME OF DECEASED (Type or print) First MIDDLE Last HENRY B. POSS		4. DATE OF DEATH Month November Day 23 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-8-1900
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Poss (Deceased)		14. MOTHER'S MAIDEN NAME Mary Windsor (Deceased)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 225-10-2523	
17. INFORMANT Louis Poss, brother, 212 Woodland Terrace		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia and atelectasis with abscess formation of lungs DUE TO (b) Right composite neck surgery (11-16-60) DUE TO (c) Carcinoma of tongue right side PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that the deceased attended the deceased from October 31, 1960, to November 23, 1960, that the deceased died on November 23, 1960, and that death occurred at 3:00 AM from the causes and on the date stated above. 22a. SIGNATURE A. L. MOONEY 22c. PHYSICIAN'S NAME (Type) A. L. MOONEY Asst. Clinical Pathologist, V.A. Hospital, Perry Point, Md. 22b. DATE SIGNED 11-23-60 22d. ADDRESS 22e. REC'D BY REGISTRAR 22f. REGISTRAR'S SIGNATURE	
23a. BURIAL, CREMATION, OR OTHER DISPOSITION		23b. DATE THEREOF 11-28-60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		25a. REC'D BY REGISTRAR NOV 29 '60	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12482

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>all life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital. D.O.A.</b>				d. STREET ADDRESS <b>152 E. Main St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Lewis</b> Last <b>Robinson</b>				4. DATE OF DEATH Month <b>11</b> Day <b>29</b> Year <b>19 60</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-27-1916</b>		9. AGE (In years last birthday) <b>44</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lewis Robinson</b>				14. MOTHER'S MAIDEN NAME <b>Blanch Draper</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW 2 212-01-2142</b>		17. INFORMANT <b>Mrs. Wm. L. Robinson, 152 E. Main St. Elkton</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Right Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Anterior sclerotic heart Disease</b> DUE TO (c) <b>not known</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Md.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R.C. Dodson</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>11-21-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/23/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Elkton Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Elkton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PIPPIN FUNERAL HOME</b>				ADDRESS <b>Donald M. Pippin, Elkton, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 28 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES J. JAMES		2. SEX Male		3. AGE 45	
4. DATE OF DEATH 11-1-11		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. SIGNATURE OF EXAMINER [Signature]	
10. SIGNATURE OF NEXT OF KIN [Signature]		11. SIGNATURE OF PHYSICIAN [Signature]		12. SIGNATURE OF CORONER [Signature]	
13. SIGNATURE OF JURY [Signature]		14. SIGNATURE OF WITNESSES [Signature]		15. SIGNATURE OF DECEASED [Signature]	
16. SIGNATURE OF DECEASED [Signature]		17. SIGNATURE OF DECEASED [Signature]		18. SIGNATURE OF DECEASED [Signature]	
19. SIGNATURE OF DECEASED [Signature]		20. SIGNATURE OF DECEASED [Signature]		21. SIGNATURE OF DECEASED [Signature]	
22. SIGNATURE OF DECEASED [Signature]		23. SIGNATURE OF DECEASED [Signature]		24. SIGNATURE OF DECEASED [Signature]	
25. SIGNATURE OF DECEASED [Signature]		26. SIGNATURE OF DECEASED [Signature]		27. SIGNATURE OF DECEASED [Signature]	
28. SIGNATURE OF DECEASED [Signature]		29. SIGNATURE OF DECEASED [Signature]		30. SIGNATURE OF DECEASED [Signature]	
31. SIGNATURE OF DECEASED [Signature]		32. SIGNATURE OF DECEASED [Signature]		33. SIGNATURE OF DECEASED [Signature]	
34. SIGNATURE OF DECEASED [Signature]		35. SIGNATURE OF DECEASED [Signature]		36. SIGNATURE OF DECEASED [Signature]	
37. SIGNATURE OF DECEASED [Signature]		38. SIGNATURE OF DECEASED [Signature]		39. SIGNATURE OF DECEASED [Signature]	
40. SIGNATURE OF DECEASED [Signature]		41. SIGNATURE OF DECEASED [Signature]		42. SIGNATURE OF DECEASED [Signature]	
43. SIGNATURE OF DECEASED [Signature]		44. SIGNATURE OF DECEASED [Signature]		45. SIGNATURE OF DECEASED [Signature]	
46. SIGNATURE OF DECEASED [Signature]		47. SIGNATURE OF DECEASED [Signature]		48. SIGNATURE OF DECEASED [Signature]	
49. SIGNATURE OF DECEASED [Signature]		50. SIGNATURE OF DECEASED [Signature]		51. SIGNATURE OF DECEASED [Signature]	
52. SIGNATURE OF DECEASED [Signature]		53. SIGNATURE OF DECEASED [Signature]		54. SIGNATURE OF DECEASED [Signature]	
55. SIGNATURE OF DECEASED [Signature]		56. SIGNATURE OF DECEASED [Signature]		57. SIGNATURE OF DECEASED [Signature]	
58. SIGNATURE OF DECEASED [Signature]		59. SIGNATURE OF DECEASED [Signature]		60. SIGNATURE OF DECEASED [Signature]	
61. SIGNATURE OF DECEASED [Signature]		62. SIGNATURE OF DECEASED [Signature]		63. SIGNATURE OF DECEASED [Signature]	
64. SIGNATURE OF DECEASED [Signature]		65. SIGNATURE OF DECEASED [Signature]		66. SIGNATURE OF DECEASED [Signature]	
67. SIGNATURE OF DECEASED [Signature]		68. SIGNATURE OF DECEASED [Signature]		69. SIGNATURE OF DECEASED [Signature]	
70. SIGNATURE OF DECEASED [Signature]		71. SIGNATURE OF DECEASED [Signature]		72. SIGNATURE OF DECEASED [Signature]	
73. SIGNATURE OF DECEASED [Signature]		74. SIGNATURE OF DECEASED [Signature]		75. SIGNATURE OF DECEASED [Signature]	
76. SIGNATURE OF DECEASED [Signature]		77. SIGNATURE OF DECEASED [Signature]		78. SIGNATURE OF DECEASED [Signature]	
79. SIGNATURE OF DECEASED [Signature]		80. SIGNATURE OF DECEASED [Signature]		81. SIGNATURE OF DECEASED [Signature]	
82. SIGNATURE OF DECEASED [Signature]		83. SIGNATURE OF DECEASED [Signature]		84. SIGNATURE OF DECEASED [Signature]	
85. SIGNATURE OF DECEASED [Signature]		86. SIGNATURE OF DECEASED [Signature]		87. SIGNATURE OF DECEASED [Signature]	
88. SIGNATURE OF DECEASED [Signature]		89. SIGNATURE OF DECEASED [Signature]		90. SIGNATURE OF DECEASED [Signature]	
91. SIGNATURE OF DECEASED [Signature]		92. SIGNATURE OF DECEASED [Signature]		93. SIGNATURE OF DECEASED [Signature]	
94. SIGNATURE OF DECEASED [Signature]		95. SIGNATURE OF DECEASED [Signature]		96. SIGNATURE OF DECEASED [Signature]	
97. SIGNATURE OF DECEASED [Signature]		98. SIGNATURE OF DECEASED [Signature]		99. SIGNATURE OF DECEASED [Signature]	
100. SIGNATURE OF DECEASED [Signature]		101. SIGNATURE OF DECEASED [Signature]		102. SIGNATURE OF DECEASED [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

12503 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12480

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN 1b <b>4 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Darlington</b> d. STREET ADDRESS <b>Rt. 2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIE</b> Middle <b>W.</b> Last <b>SCRUGGS</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>18</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 19, 1896</b>
9. AGE (In years lost birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Work</b>	
11. BIRTHPLACE (State or foreign country) <b>Kieffer, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clinton Scruggs</b>		14. MOTHER'S MAIDEN NAME <b>Hilda McDowell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WWI</b>		16. SOCIAL SECURITY NO. <b>245057616</b>	
17. INFORMANT <b>Fred Anderson, Rt. 2, Darlington, Md. (Friend)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cor Pulmonale</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary fibrosis with marked emphysema</b> DUE TO (c) <b>Fibro-caseous tuberculosis, bilateral</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>VA</b> attended the deceased from <b>Nov. 14</b> to <b>Nov. 18</b> , 19 <b>60</b> and that death occurred at <b>3:29 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>A. L. Mooney</b>		22b. DATE <b>November 19, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. L. MOONEY, M.D.</b>		22d. ADDRESS <b>Asst. Clin. Pathologist VAH., Perry Point, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-22-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>PENNINGTON &amp; SON</b>		25a. REC'D BY REGISTRAR <b>NOV 23 '60</b>	
ADDRESS <b>Havre de Grace, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Robert L. Haines</b>	

1500

CERTIFICATE OF DEATH

1500

Name of Deceased: [illegible] Sex: [illegible] Age: [illegible] Date of Birth: [illegible]

Place of Birth: [illegible] Date of Death: [illegible] Time of Death: [illegible]

Cause of Death: [illegible] Nature of Death: [illegible]

Signature of Physician: [illegible] Signature of Registrar: [illegible]

Date of Issuance: [illegible] Place of Issuance: [illegible]

Signature of Deceased: [illegible] Signature of Next of Kin: [illegible]

Signature of Medical Examiner: [illegible] Signature of Coroner: [illegible]

Signature of Burial Officer: [illegible] Signature of Minister of Religion: [illegible]

Signature of Undertaker: [illegible] Signature of Funeral Home: [illegible]

Signature of Cemetery: [illegible] Signature of Graveyard: [illegible]

Signature of Burial: [illegible] Signature of Interment: [illegible]

Signature of Burial: [illegible] Signature of Interment: [illegible]

Signature of Burial: [illegible] Signature of Interment: [illegible]

Signature of Burial: [illegible] Signature of Interment: [illegible]

Signature of Burial: [illegible] Signature of Interment: [illegible]

Signature of Burial: [illegible] Signature of Interment: [illegible]

Signature of Burial: [illegible] Signature of Interment: [illegible]

Signature of Burial: [illegible] Signature of Interment: [illegible]

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12483

CERTIFICATE OF DEATH

Reg. Dist. No.

13220

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Devine Nursing Home</u>		d. STREET ADDRESS <u>Rd # 2,</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles P.</u> Middle <u>Sheppard</u> Last <u></u>		4. DATE OF DEATH Month <u>11</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/2/1872</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Sheppard</u>	
14. MOTHER'S MAIDEN NAME <u>Rebeca Carter</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>	
16. SOCIAL SECURITY NO. <u>---</u>		INFORMANT Address <u>Mrs Viola Bistic Rd#2 Elkton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of lung</u> 163X DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>April 10, 1956</u> to <u>April 21, 1960</u> , that I last saw the deceased alive on <u>Nov. 20, 1960</u> , and that death occurred at <u>4:05</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>CHESAPEAKE CITY MD</u> DATE SIGNED <u>11/21/60</u>			
ACTUAL SIGNATURE <u>Henry U. Davis</u> M.D.		PHYSICIAN'S NAME (Type) <u>HENRY U. DAVIS M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/23/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cherry Hill Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Cherry Hill Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Walter DuBois</u> ADDRESS <u>Elkton Md</u>		24a. RECEIVED BY REGISTRAR <u>NOV 28 '60</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

1895

CERTIFICATE OF DEATH

1895

1



**00 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, the page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

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VR AIS (4)  
15M 9/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

12484

13221

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Nursing Home		d. STREET ADDRESS Cannon St.	
3. NAME OF DECEASED (Type or print) First Middle Last Clara L. Sutton		4. DATE OF DEATH Month Day Year Nov. 23, 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/11/1875
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Samuel Mann		14. MOTHER'S MAIDEN NAME Mary Wilmer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Ruth Ann Sutton		308 Park Row Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 days year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) fracture of pelvis - 3 months before			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 13, 1960, to 23 Nov., 1960 that (I) (we) lost the deceased alive on 23 Nov., 1960 and that death occurred at 11:45 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Wallace Obenchain		22b. DATE SIGNED 23 Nov 1960	
22c. PHYSICIAN'S NAME (Type) Wallace Obenchain		22d. ADDRESS Cecilton, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/27/60	
23c. NAME OF CEMETERY OR CREMATORY Still Pond Cem.		23d. LOCATION (City, town, or county) (State) Still Pond, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. L. Willis		25a. REC'D BY REGISTRAR DATE NOV 29 '60	
ADDRESS Chestertown, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Thoms	

1964

CHRONOLOGICAL INDEX

12184



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records or to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12481

12504

Item 8 Film G276 12-5-60 et

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ferdricktown		c. LENGTH OF STAY IN 1b 1 hr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last James Wilbur Webb		4. DATE OF DEATH Month Day Year Nov. 16 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1893 Jan. 1, 1892
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Webb	
14. MOTHER'S MAIDEN NAME Kathryn A. Webb		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address George W. Webb Rural Kennedyville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dr. R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 19, 1960	
22c. NAME OF CEMETERY OR CREMATORY Shrewsbury Cemetery		22d. LOCATION (City, town, or county) (State) Rural Kennedyville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Edward Wilbur Millington Md.		24a. REC'D BY REGISTRAR DATE NOV 28 '60	
		24b. REGISTRAR'S SIGNATURE Arthur L. Evans	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

12505

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12482

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>			c. LENGTH OF STAY IN 1b <b>1mo. 26days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Northeast</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>H.</b> Last <b>WHARTON</b>		4. DATE OF DEATH Month <b>November</b> Day <b>1</b> Year <b>19 60</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-22-93</b>		9. AGE (In years lost birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Molder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brick Company</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Benjamin Wharton (Deceased)</b>				14. MOTHER'S MAIDEN NAME <b>Emma Bayer (Deceased)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW-I 212-18-6158</b>		17. INFORMANT Address <b>Mrs. Fannie Wharton, wife, Northeast, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia bilateral unresolved</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Metastatic adenocarcinoma of the rectum with unknown</b> DUE TO <b>metastases to the lungs, liver &amp; abdominal lymph nodes</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, generalized, moderate</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4-5 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>Dr. J. L. Garey</b> attended the deceased from <b>September 6 19 60</b> to <b>November 1 19 60</b> and that death occurred at <b>12:42a</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>J. L. Garey</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11-1-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. L. GAREY, Clinical Pathologist</b>				22d. ADDRESS <b>V.A. Hospital, Perry Point, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-5-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Methodist</b>		23d. LOCATION (City, town, or county) (State) <b>North East Cecil Co Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grank</b>				ADDRESS <b>North East Md</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 3 '60</b>	
						25b. REGISTRAR'S SIGNATURE <b>Charles E. Harris</b>	

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CERTIFICATE OF DEATH

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*J. H. H. H.*

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CERTIFICATE OF DEATH

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